# MCO BASELINE ASSESSMENT:
# INFORMATION SYSTEM CAPABILITIES

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## I. GENERAL INFORMATION

Please provide the following general information.

**A. Managed Care Model Type: (circle one)**

HMO-Staff HMO-Group HMO-IPA HMO-Mixed Other: _____

**B. Year Incorporated**

_____

**C. Member Enrollment for Last Three (3) Years:**

| | 1999 | 1998 | 1997 |
|---|---|---|---|
| Privately Insured | _____ | _____ | _____ |
| Medicare | _____ | _____ | _____ |
| Medicaid | _____ | _____ | _____ |
| Other | _____ | _____ | _____ |

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## II. DATA ACQUISITION CAPABILITIES

The purpose of this section is to obtain a high-level understanding of how you collect and maintain claims/encounters, enrollment information and data on ancillary services such as prescription drugs.

### A. Administrative Data (Claims and Encounter Data)

This section requests information on input data sources (e.g., paper and electronic claims) and on the transaction system(s) you use.

1. Do you use standard claims or encounter forms? If so, please specify (e.g., HCFA 1500, UB92).

Hospital: _____
Physician: _____
Drug: _____
Other: _____

2. We would like to understand the means by which claims or encounters are submitted to your plan. We also are interested in an estimate of what percentage (if any) of services provided to your enrollees are not submitted as claims or encounters and therefore are not represented in your administrative data. Please provide the following percentages:

| | Claims/Encounter Type | | | | |
|---|---|---|---|---|---|
| **Medium** | **Hospital** | **Physician** | | **Drug** | **Other** |
| | | **PCP** | **Specialist** | | |
| Claims/encounters submitted electronically | | | | | |
| Claims/encounters submitted on paper | | | | | |
| Services not submitted as claims or encounters | | | | | |
| **TOTAL** | **100%** | **100%** | **100%** | **100%** | **100%** |

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3. Please document whether the following data elements are required for each of the types of claims/encounters identified below. If required, enter an "R" in the appropriate box.

| | Claims/Encounter Type | | | | |
|---|---|---|---|---|---|
| **Data Elements** | **Hospital** | **Physician** | | **Drug** | **Other** |
| | | **PCP** | **Specialist** | | |
| Patient Gender | | | | | |
| Patient DOB/Age | | | | | |
| Diagnosis | | | | | |
| Procedure | | | | | |
| First Date of Service | | | | | |
| Last Date of Service | | | | | |
| Revenue Code | | | | | |
| Provider Specialty | | | | | |

4. How many diagnoses are captured on each claim? On each encounter?

| | Claim | Encounter |
|---|---|---|
| Institutional Data: | _____ | _____ |
| Professional Data: | _____ | _____ |

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5. Can you distinguish between principal and secondary diagnoses?

6. System Overview Flowcharts: Please provide a high-level overview of the structure of your management information system(s).

7. Please explain what happens if a claim/encounter is submitted and one or more required fields are missing. incomplete or invalid. For example, if diagnosis is not coded, is the claims examiner required by the system to use an on-line software product like AutoCoder to determine the correct ICD-9 code?

   Institutional Data:

   Professional Data:

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8. What steps do you take to verify the accuracy of submitted information (e.g., procedure code-diagnosis code edits, gender-diagnosis, gender-procedure code edits)?

   Institutional Data:

   Professional Data:

9. Under what circumstances can claims processors change claims/encounter information?

10. Identify any instance where the content of a field is intentionally different from the description or intended use of the field. For example, if the dependent's SSN is unknown, do you enter the member's SSN instead?

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11. Are claims/encounters received directly from the provider (i.e., hospital, physician, pharmacy) or do they go through an intermediary? If the data are submitted through an intermediary, what changes, if any, are made to the data?

12. Please estimate the percentage of claims/encounters that are coded using the following coding schemes:

| Coding Scheme | Inpatient Diagnosis | Inpatient Procedure | Ambulatory/ Outpatient Diagnosis | Ambulatory/ Outpatient Procedure | Drug Diagnosis |
|---|---|---|---|---|---|
| ICD-9-CM | | | | | |
| CPT-4 | | | | | |
| HCPCS | | | | | |
| DSM-IV | | | | | |
| Internally-Developed | | | | | |
| Other (specify) | | | | | |
| Not Required | | | | | |
| **TOTAL** | **100%** | **100%** | **100%** | **100%** | **100%** |

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13. Please describe any recent (i.e., within the last three years) upgrades or consolidations of your information systems.

14. For each Medicaid HEDIS measure identified below, please indicate the data source/method you would use:

| Medicaid HEDIS Measure | Administrative Data Only | Medical Record Review Only | Hybrid Method |
|---|---|---|---|
| Childhood Immunization Rates | | | |
| Well Child Visits | | | |
| Adolescent Well Care Visits | | | |
| Substance Abuse Counseling for Adolescents | | | |
| Cervical Cancer Screening | | | |
| Low Birthweight | | | |
| Initiation of Prenatal Care | | | |
| Prenatal Care Utilization | | | |
| Glycohemoglobin Monitoring | | | |
| Ambulatory Follow-Up After Hospitalization for Mental Health Disorders | | | |
| Utilization of PCPs, Preventive Services | | | |
| Provider Availability (Access) | | | |

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**B. Enrollment System**

1. Please describe any major changes in the enrollment system(s) which could affect the quality or completeness of the enrollment data.

2. How does your plan uniquely identify members?

3. How do you handle member disenrollment and re-enrollment in the same product? Does the member retain the same ID?

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**C. Ancillary Systems**

1. Does your plan incorporate data from vendors to calculate any of the following quality measures? If so, which measures require vendor data?

| Measure | Vendor Name |
|---|---|
| Childhood Immunization Rate(s) | |
| Well Child Visits | |
| Initiation of Prenatal Care | |
| Cervical Cancer Screening | |
| Low Birthweight | |
| Prenatal Care in First Trimester | |
| Substance Abuse Counseling for Adolescents | |
| Glycohemoglobin Monitoring | |
| Ambulatory Follow-Up After Hospitalization for Specified Mental health Disorders | |
| Provider Certification | |

2. Discuss any concerns you may have about the quality or completeness of any vendor data.

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## III. COMPENSATION STRUCTURE

The purpose of this section is to evaluate the provider compensation structure, as this may influence the quality and completeness of data. Please identify the percentage of member months in your plan contributed by members whose primary care providers and specialists are compensated through each of the following payment mechanisms.

| Payment Mechanism | Provider Type | |
|---|---|---|
| | PCP | Specialist |
| 1. Salaried | | |
| 2. Fee-for-Service - no withhold or bonus | | |
| 3. Fee-for-Service with withhold<br>% withhold | | |
| 4. Fee-for-service with bonus<br>Bonus range: | | |
| 5. Capitated - no withhold or bonus | | |
| 6. Capitated with withhold<br>% withhold: | | |
| 7. Capitated with bonus<br>Bonus range: | | |
| 8. Other: | | |
| **TOTAL** | **100%** | **100%** |